

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

1 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## CERTIFICATE OF DEATH

Reg. Dist. No. 07941

06466

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Calvert</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Prince Frederick</u>		LENGTH OF STAY (In this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lusby, Maryland</u>		<u>0471</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 79</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Edith F. Applegate</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>5 31 19 67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>7-26-85</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>XXXXXXXXXX Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Charles W. Foltz</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN Dietrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>		17. INFORMANT & ADDRESS <u>Meiba M. Foltz</u> <u>2700 Conn. Ave., Washington, D.C.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
1533 IMMEDIATE CAUSE (A) <u>Carcinoma of sigmoid</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastatic Ca of rectum</u>				<u>6 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>April</u> , 19 <u>66</u> , to <u>5/31</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>67</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Prince Frederick Md</u>				DATE SIGNED <u>5/31/67</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-3--1967</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) <u>Prince George's Co. Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawlers Sons, Inc. Wash. D.C.</u>			
DATE <u>JUN 7 1967</u>							



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06467

CERTIFICATE OF DEATH

06454

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. STREET ADDRESS <b>441</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Commodore Boots</b>		4. DATE OF DEATH Month Day Year <b>May 6 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-87</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Major Commodore</b>		14. MOTHER'S MAIDEN NAME <b>Grace Freeland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James O. Chase, Prince Frederick, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure a</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>anemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Issam El Damalouji, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Issam El Damalouji, M.D.</b>		22d. ADDRESS <b>Prince Frederick, Maryland</b>	
23a. (BURIAL, CREMATION, REMOVAL) (Specify) <b>5/10/67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Brown's Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Calvert Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Robney E. Swell</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAY 12 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORD OF

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

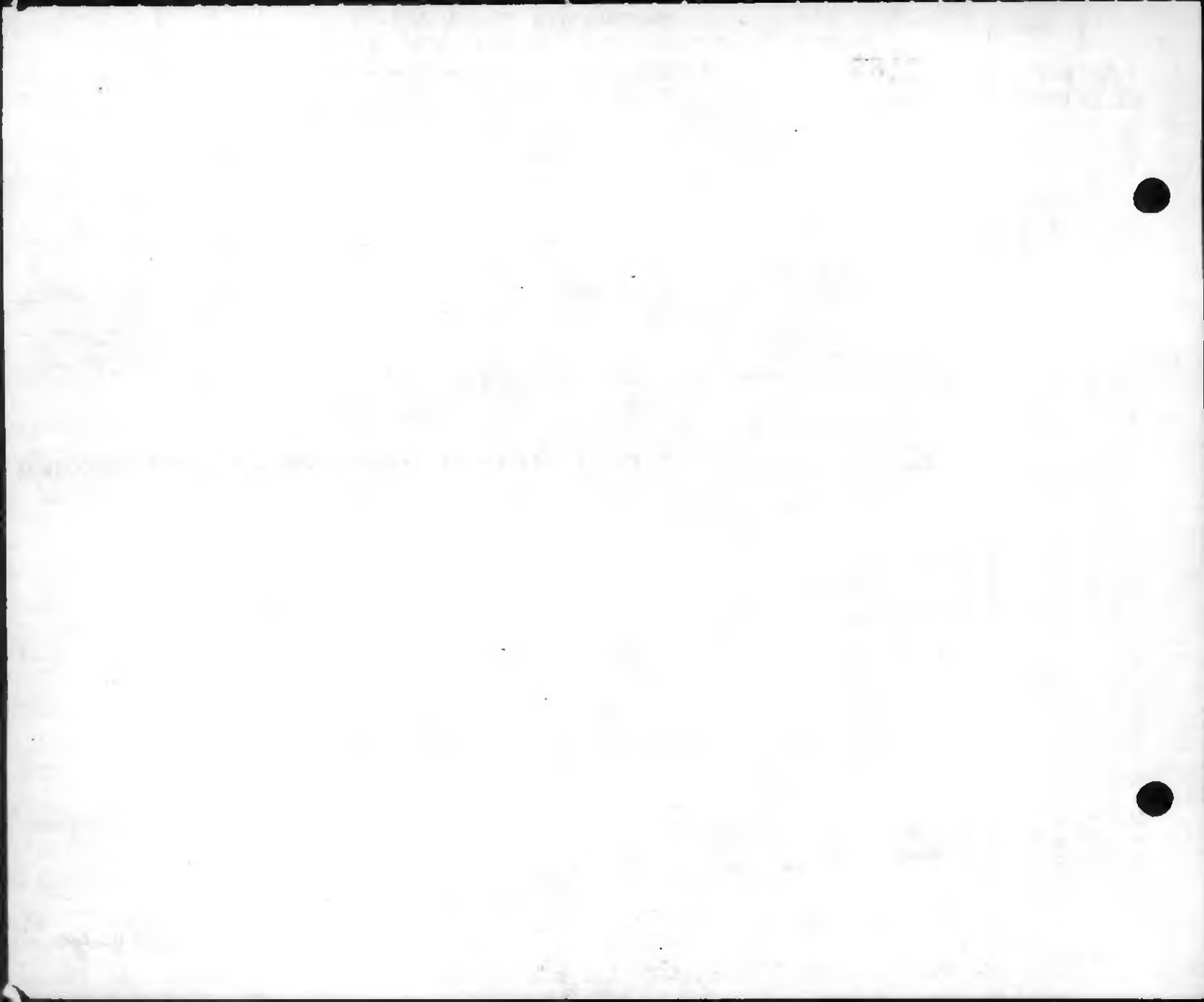
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06468

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06455

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(rural)</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sham</u> Middle <u>Ray</u> Last <u>Bowen</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/09/10</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sham Bowen Jr.</u>		14. MOTHER'S MAIDEN NAME <u>May Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-551</u>	
17. INFORMANT <u>Dorothy Turner Bowen, Prince Frederick</u>		Address <u>Prince Frederick</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7824</u> IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) <u>(b)</u> DUE TO (c) <u>(c)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in car on road 231</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Slipped car in Charles Street</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>9:30</u> <u>5</u> <u>4</u> <u>1967</u> Hour <u>0</u> a.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barstow</u>		20f. (City or town) <u>Calvert</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. Ward M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>5/4/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City or Town) <u>Prince Frederick</u> (County) <u>Calvert</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>A. G. Thelwell &amp; Son, Port Republic, Md.</u>		25a. REC'D BY REGISTRAR <u>May 8, 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

06463

**CERTIFICATE OF DEATH**

06456

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Prince Frederick</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Solomons</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Rhoda Vera Dean</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>5 4 19 67</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-09</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles G. Travers</u>			14. MOTHER'S MAIDEN NAME <u>Winnie Simmons</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-34-4630</u>		17. INFORMANT <u>Joan Wroten</u> Address <u>Solomons, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1538 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>prob ca of Colon</u> (c) <u>metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1965</u> , to <u>May 4, 1967</u> that (I) (we) last saw the deceased alive on <u>May 4, 1967</u> , and that death occurred at <u>3:30am</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Roberto de Villarreal, M.D.</u>			22d. ADDRESS <u>St. Leonard, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Solomons Calvert Md.</u>			
24. FUNERAL DIRECTOR <u>A.A. &amp; Son</u>			25a. REC'D BY REGISTRAR <u>Port Republic</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

The first part of the report is a general  
 description of the area. It is a small  
 area, about 100 acres in size, and is  
 located in the north-east corner of the  
 park. The area is mostly flat, with a few  
 small hills. The vegetation is mostly  
 grass, with some trees and shrubs.  
 The area is used for grazing by cattle  
 and sheep. The water in the area is  
 mostly from the rain, and is not  
 very good. The water is very hard, and  
 is not good for drinking. The water is  
 also very dirty, and is not good for  
 washing. The water is also very  
 hot, and is not good for bathing.  
 The area is also very dry, and is not  
 good for growing crops. The area is  
 also very hot, and is not good for  
 living. The area is also very dry, and  
 is not good for growing crops. The  
 area is also very hot, and is not good  
 for living. The area is also very dry,  
 and is not good for growing crops.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06470

06457

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) <b>Lucretia Hilken Dowell</b>				4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-89</b>		9. AGE (In years last birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Hilken</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Becker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-4356</b>		17. INFORMANT <b>Arthur Dowell</b>		Address <b>Prince Frederick, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5480 Vasomotor shock</b> DUE TO (b) <b>from negative Basilemia</b> DUE TO (c) <b>gas in embolized circulation + hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Obesity</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1967</b> , to <b>May 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 21, 1967</b> , and that death occurred at <b>12 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Page C. Jett</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Page C. Jett M.D.</b>				22d. ADDRESS <b>Prince Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Prince Frederick Calvert Md.</b>	
24. FUNERAL DIRECTOR <b>A.A. Harkness &amp; Son</b>				ADDRESS <b>Port Republic</b>		25a. REC'D BY REGISTRAR <b>MAY 24 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles J. Jett</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Calvert

Calvert

Calvert

Prince Frederick

1972

Prince Frederick

Calvert County Hospital

SI

SI

SI

11-10-72

11-10-72

New York

Caroline Water

John A. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36471

8

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake Beach</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. STREET ADDRESS <b>Box 344</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret Madeline Fay</b>		4. DATE OF DEATH Month <b>5-</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-29-02</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>23</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE F. Lerch</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Albright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Edward A. Fay</b>		Address <b>Chesapeake Beach, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per use for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Major medical infection</b> 42.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 5</b> , 19 <b>66</b> , to <b>Jan. 24</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>May 23</b> , 19 <b>67</b> , and that death occurred at <b>4:10 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>George J. Weems</b>		22b. DATE SIGNED <b>5/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>George J. Weems, M.D.</b>		22d. ADDRESS <b>Huntingtown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 26 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEAR HILL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>SUITLAND MD</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1967</b>	
ADDRESS <b>RIVERDALE, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

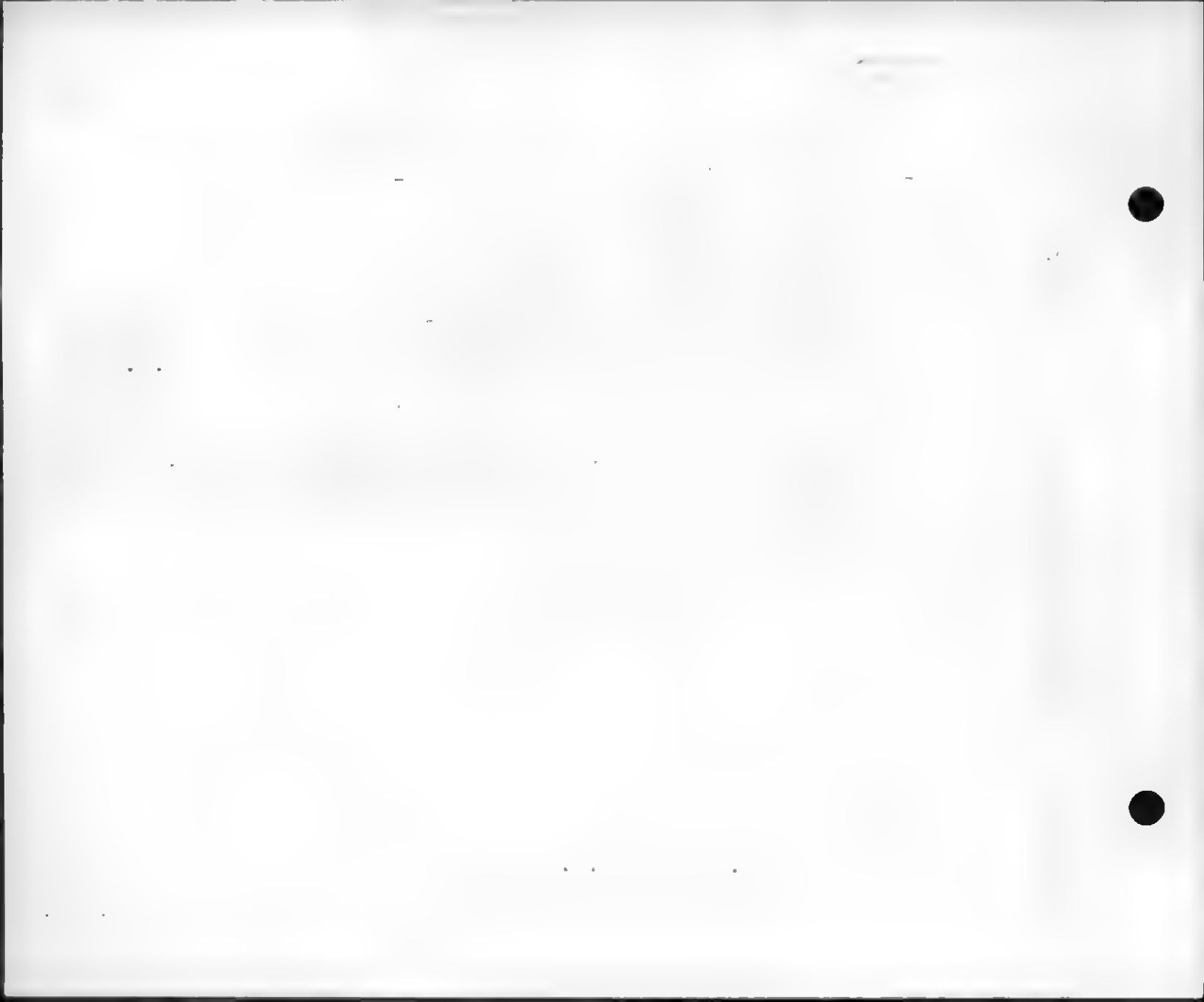
CERTIFICATE OF DEATH

36472

1 PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>			c. LENGTH OF STAY IN 1b <b>48 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>			d. STREET ADDRESS		
3 NAME OF DECEASED (Type or print) First Middle Last <b>Wallace Asbury Gibson</b>			4 DATE OF DEATH Month Day Year <b>5 14 19 67</b>		
5 SEX <b>male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-91</b>		9. AGE (In years last birthday) <b>75 yrs</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Barry Gibson</b>			14. MOTHER'S MAIDEN NAME <b>Georgianna</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>579-03-1147</b>		17 INFORMANT <b>Nellie Gibson</b> Address <b>Owings, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of storm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____					INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 8</b> , 19 <b>66</b> , to <b>May 14</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>May 14</b> 1967, and that death occurred <b>2:10 p.m.</b> from causes and on the date stated above					
22a SIGNATURE <i>George J. Weems</i>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>George J. Weems, M.D.</b>			22d. ADDRESS <b>Huntingtown, Maryland</b>		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>5-18-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Mt. Hope, Ch. Cem.</b>		23d LOCATION (City or town) (County) (State) <b>Sunderland Cal. Md.</b>	
24 FUNERAL DIRECTOR <b>Linkey E. Sowell Prince Georges</b>			25. REC'D BY REGISTRAR <b>MAY 18 1967</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

06473

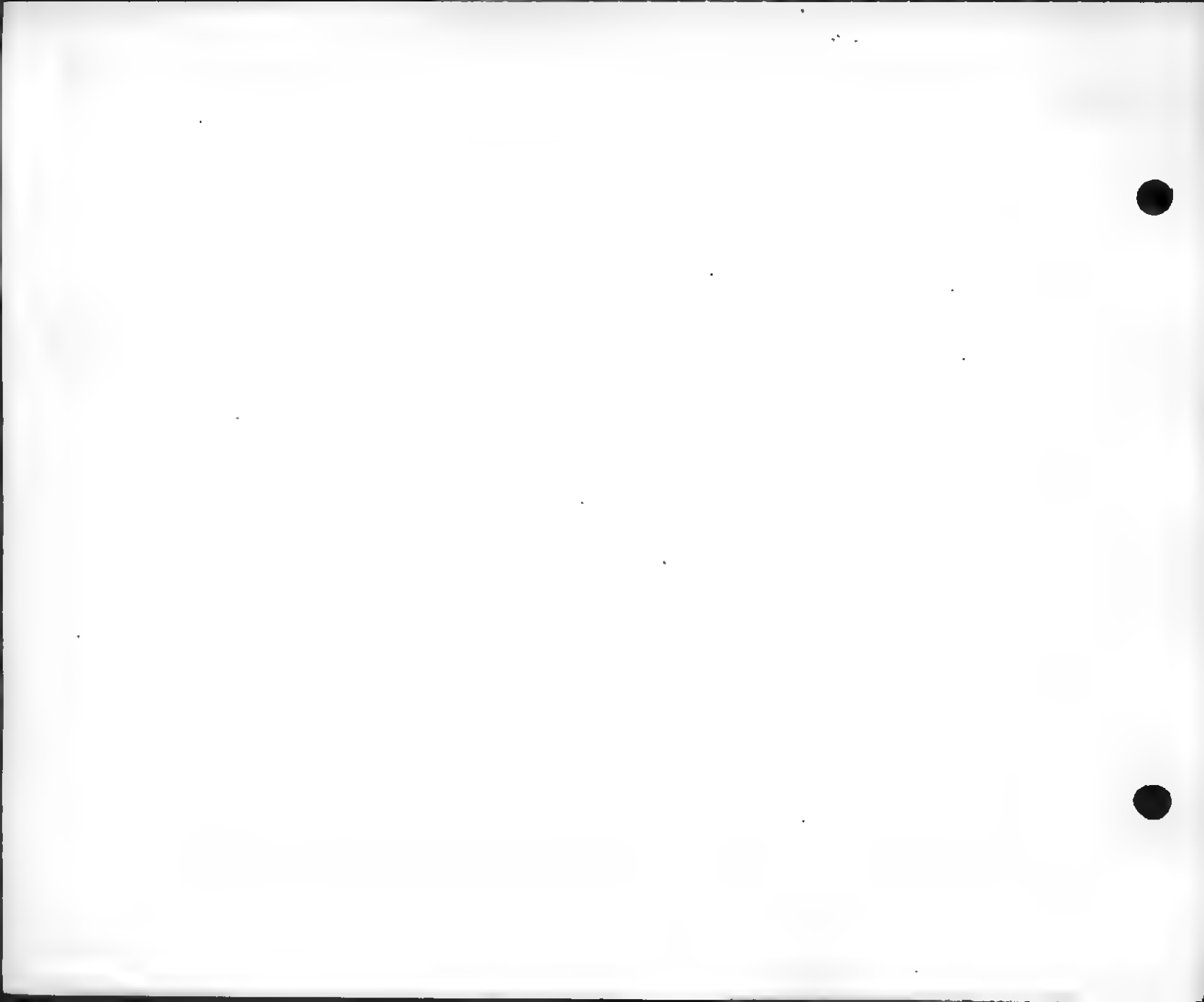
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Cabert</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>Cabert</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		c LENGTH OF STAY IN 1b <u>114</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Robert Franklin Jack</u>		4 DATE OF DEATH <u>5</u> Month <u>5</u> Day <u>17</u> Year	
5 SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 1909</u>
9 AGE (In years, last birthday) <u>57</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>
11 BIRTHPLACE (State or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Wm Jacks</u>		14 MOTHER'S MAIDEN NAME <u>Luvemia Wilks</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>214-143931</u>	17 INFORMANT Address <u>Ells Jacks - North Beach, MD</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured head in bed</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF DEATH Month, Day, Year <u>7</u> Hour a.m. <u>5</u> p.m. <u>5</u> 19 <u>67</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home farm factory, street, office, blog, etc.) <u>Home</u>	20f (City or town) <u>N. Beach</u> (County) <u>Cabert</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. L. Wind</u> M.D.		22. DATE SIGNED <u>5/5/67</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>5-11-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Wards Church Cem.</u>	23d LOCATION (City or Town) <u>Cabert Co. MD</u> (County) (State)
24 FUNERAL DIRECTOR <u>Pinkey E. Sewell - Prince Frederick, MD</u>		25a REC'D BY REGISTRAR <u>MAY 12 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

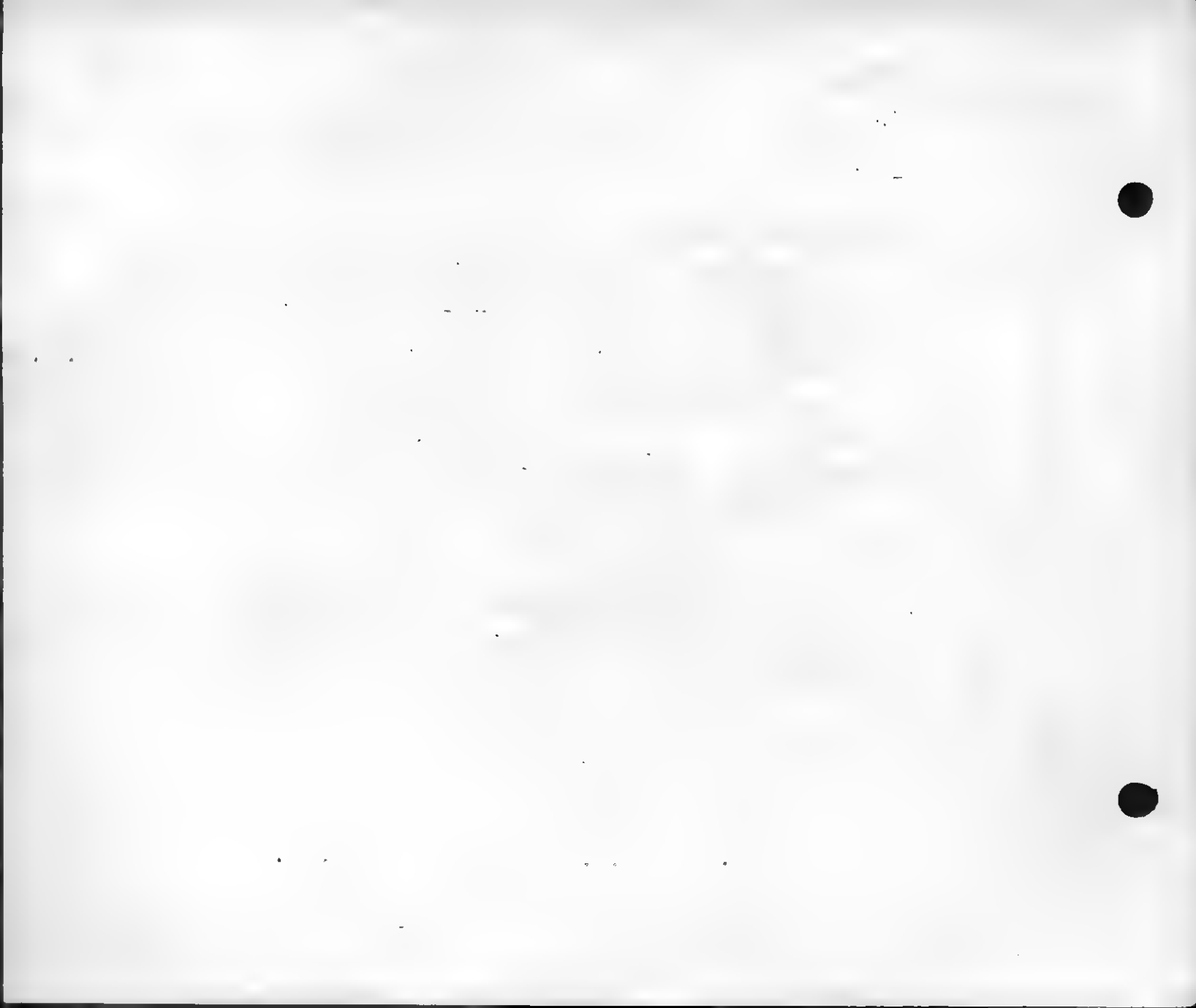
06474

41

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		c. LENGTH OF STAY IN TB <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>		e. STREET ADDRESS <b>Owings</b>	
3. NAME OF DECEASED (Type or print) First <b>Hunter</b> Middle <b>Walters</b> Last <b>Milhado</b>		4. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-92</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Police, Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Edward Watson Milhado</b>		14. MOTHER'S MAIDEN NAME <b>Ella Trice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Army</b>		16. SOCIAL SECURITY NO <b>220-12-8181</b>	
17. INFORMANT <b>Helen Milhado</b>		Address <b>Owings, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>1142X</b> IMMEDIATE CAUSE (a) <b>Coronary Vascular Renal Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Has been sick 5 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:02</b> p.m. <b>5/24/67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/20/67</b> to <b>5/24/67</b> , that (I) (we) last saw the deceased alive on <b>27/24/67</b> , and that death occurred at <b>2:05 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>H. W. Ward</b>		22b. DATE SIGNED <b>5-25-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hugh W. Ward, M.D.</b>		22d. ADDRESS <b>Owings, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Ch. Cem</b>		23d. LOCATION (City or town) (County) (State) <b>Friendship A. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings, Md.</b>		25. REGISTRAR'S SIGNATURE <b>James Judge</b>	



96475

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curwings</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route 1 Chesapeake Beach.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kadgett Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Susanna PORTER</u>				4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3 1882</u>	9. AGE (in years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>31</u>		IF UNDER 24 HRS Hours <u>0</u> Mins <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Reutrich</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Wolfe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-466303</u>		17. INFORMANT <u>Carroll D. Porter Chesapeake Beach, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis C.V. Disease</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arteriosclerosis C.V. Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>66</u> , to <u>5/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> , 19 <u>67</u> , and that death occurred at <u>7p</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Page C. Jett</u>				22b. DATE SIGNED <u>5/31/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dallas City Cem</u>	
23d. LOCATION (City or Town) <u>Illinois Hancock, Md.</u>				23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		23f. DATE <u>JUN 5 1967</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/66

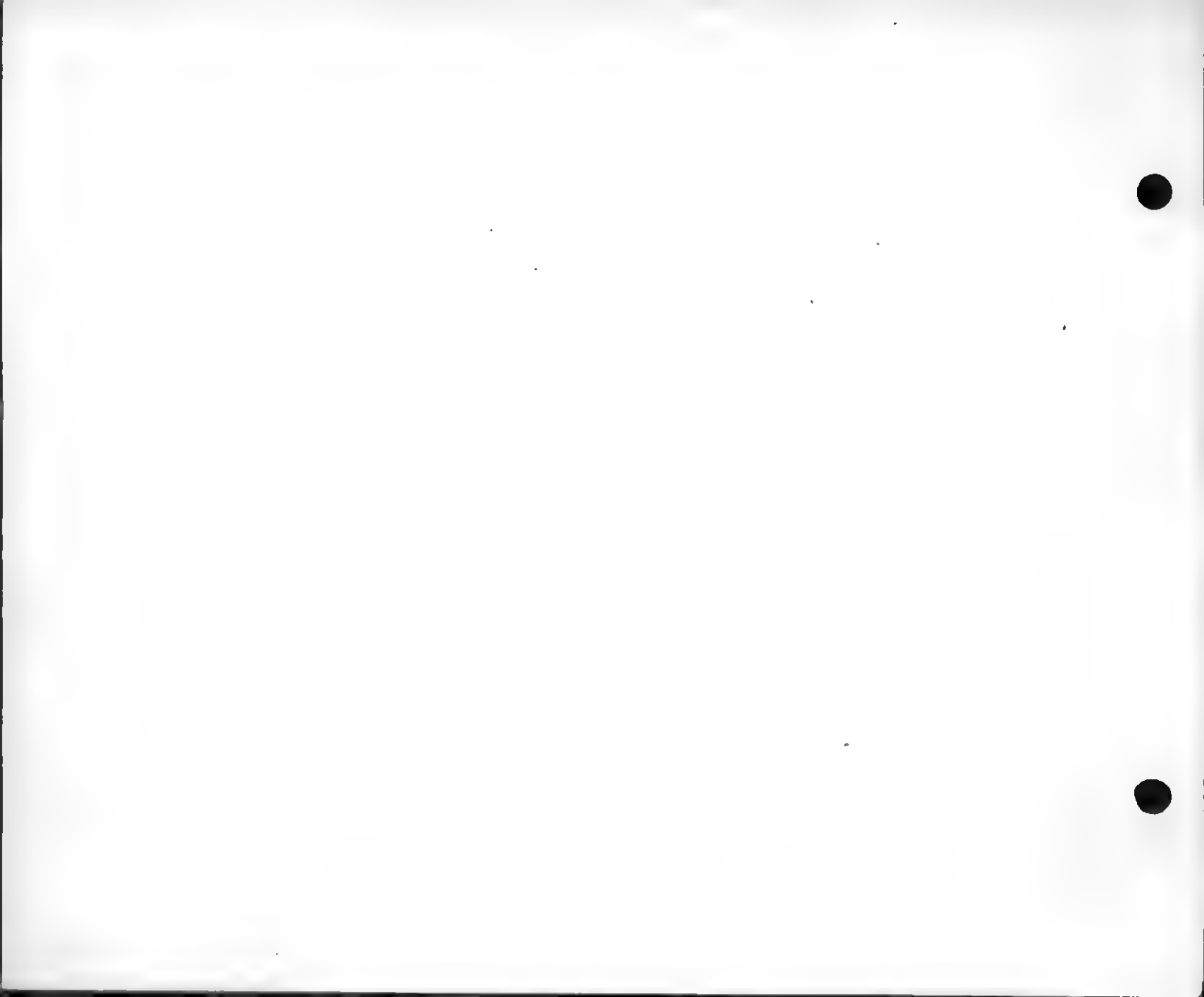
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96476

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3

1. PLACE OF DEATH a COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>Calvert</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Princess Anne</u>				c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d STREET ADDRESS <u>116</u>			
3 NAME OF DECEASED (Type or print) <u>Debra C. Randall</u> First Middle Last				4 DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>C</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/17/72</u>		9 AGE (In years last birthday) <u>7</u> yts	10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Student</u>				10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (State or foreign country) <u>MD</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>				13 FATHER'S NAME <u>David Randall</u>			
14 MOTHER'S MAIDEN NAME <u>Catherine</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>			
16 SOCIAL SECURITY NO. <u>100</u>				17 INFORMANT <u>Debra Randall</u> Address <u>116</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Cardiac arrest</u> DUE TO (b) <u>Cyanosis</u> DUE TO (c) <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Had been wheeled for two hrs</u>							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c TIME OF INJURY Month Day Year <u>6/10 5:54 1967</u>			
20d INJURY OCCURRED While <input type="checkbox"/> or Not While <input checked="" type="checkbox"/> at work				20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f CITY OR TOWN (County) <u>Cambridge</u> (State) <u>MD</u>				20g (County) <u>Calvert</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. H. W. L.</u> M.D.				22. DATE SIGNED <u>5/4/67</u>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>5-8-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Carters Ch. Cem</u>		23d LOCATION (City or Town) (County) (State) <u>Friendship P. A. H. MD</u>	
24 FUNERAL DIRECTOR <u>P. E. Sewell - Prince Frederick, MD</u>				25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 12 1967</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 are retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

26477

1. PLACE OF DEATH  
a. COUNTY *Calvert* MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) *Prince Frederick*

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) *Cal Co. Hospital*

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE *Maryland* b. COUNTY *Calvert*

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) *Pesapeake Beach*

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) *Thomas Carlyle Ross*

4. DATE OF DEATH Month *May* Day *9* Year *1967*

5. SEX *M* 6. COLOR OR RACE *W* 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH *10/3/1898*

8. AGE (In years last birthday) *68* yrs. 9. UNDER 1 YEAR ☐ IF UNDER 24 HRS. Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Waterman*

11. BIRTHPLACE (County & State, or foreign country) *Talbot Maryland*

12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *Thomas J. Ross*

14. MOTHER'S MAIDEN NAME *Sarah Harrison*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *no*

16. SOCIAL SECURITY NO. *none*

17. INFORMANT Address *Mrs. Eleanora Morgan, Elkton, Md.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) *Myocardial Infarction*  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b) *Myocardial Infarction*  
(c), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. *19*

20d. INJURY OCCURRED While ☐ Not While ☐ et work et work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from *8-10* *1967* to *5/9* *1967*, that (I) (we) last saw the deceased alive on *5/5* *1967*, and that death occurred at *8:35* *A.M.* from the causes and on the date stated above.

22a. SIGNATURE *[Signature]* M.D.

22b. DATE SIGNED *5/9/67*

22c. PHYSICIAN'S NAME (Type) *Huntingtown, Md*

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) *Buried*

23b. DATE THEREOF *5/12/1967*

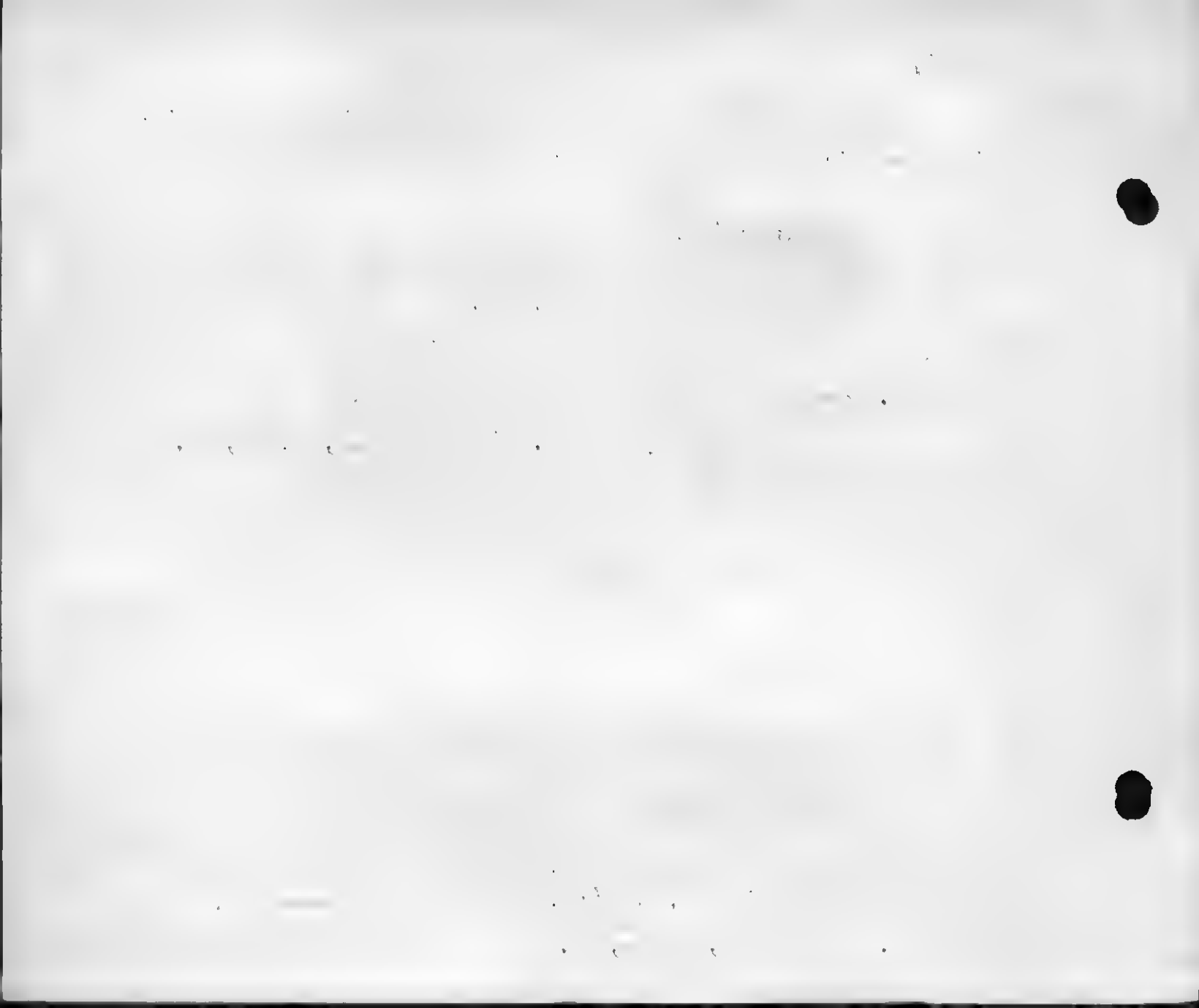
23c. NAME OF CEMETERY OR CREMATORY *St. John's Cemetery*

23d. LOCATION (City, town or county) (State) *Telghman, Md.*

24. FUNERAL DIRECTOR'S SIGNATURE *MARJORIE E. NEWMAN & SON, Easton, Md.* ADDRESS

25a. REC'D. BY REGISTRAR DATE *MAY 15 1967*

25b. REGISTRAR'S SIGNATURE *[Signature]*



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

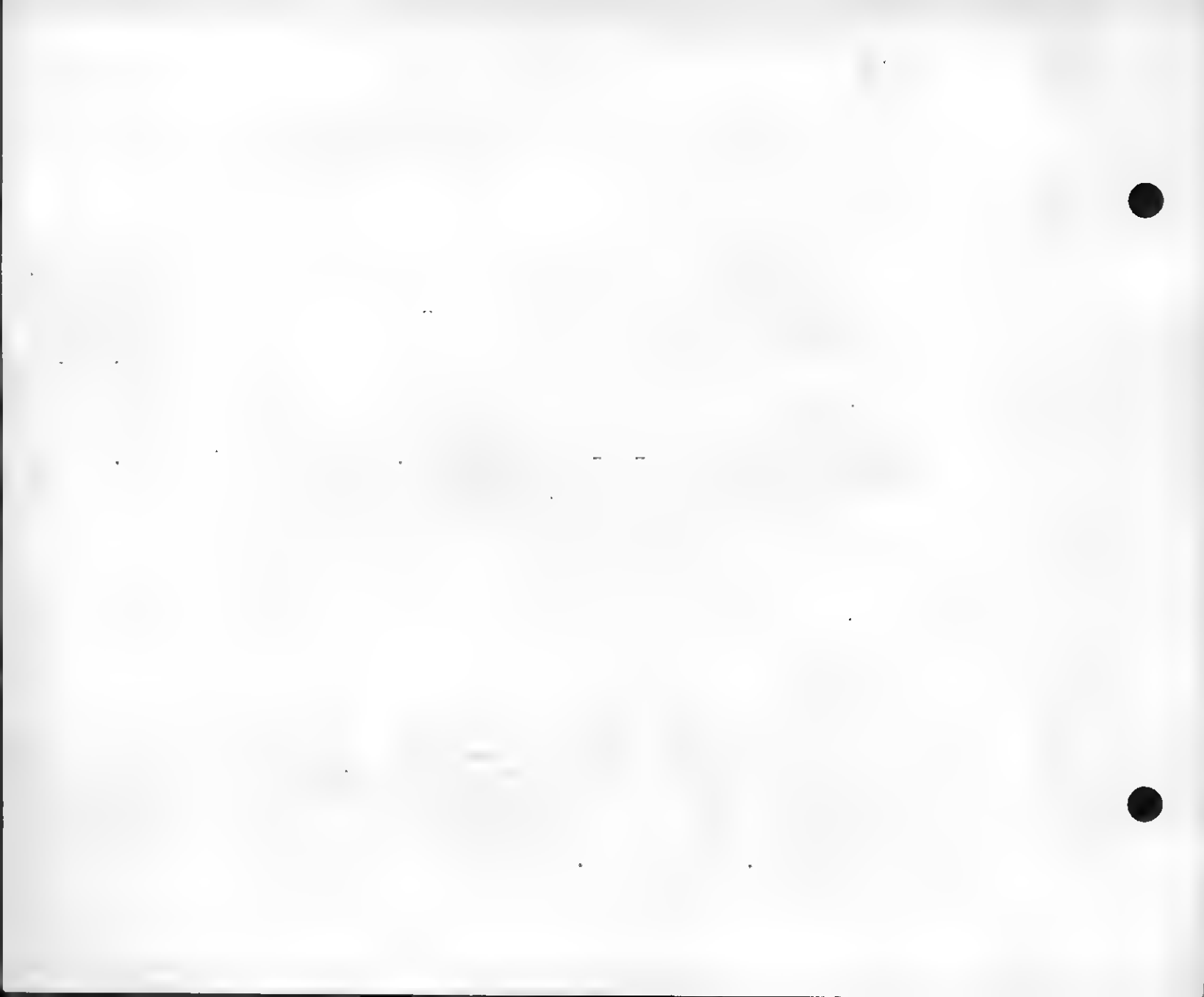
CERTIFICATE OF DEATH

36478

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>				c. LENGTH OF STAY IN TB <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d STREET ADDRESS <b>Dunkirk</b>			
3. NAME OF DECEASED (Type or print) First <b>Rosie</b> Middle <b>Estelle</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>19 67</b>			
5 SEX <b>female</b>	6 COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-84</b>	9. AGE (In years last birthday) yrs <b>82</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Peter Hicks</b>	
13. FATHER'S NAME <b>Peter Hicks</b>		14 MOTHER'S MAIDEN NAME <b>Drusilla Green</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <b>219-56-2271</b>	
15. FATHER'S NAME <b>Peter Hicks</b>		16 SOCIAL SECURITY NO <b>219-56-2271</b>		17 INFORMANT <b>Allen L. Smith</b>		18 ADDRESS <b>Dunkirk, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart Dis.</b> DUE TO (b) <b>Congestive heart failure</b> DUE TO (c) <b>Uremia.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 19 65</b> to <b>May 1, 19 67</b> that (I) (we) last saw the deceased alive on <b>May 1, 19 67</b> , and that death occurred at <b>5:25 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Osman Z. Ersoy, M.D.</b>				22b. DATE SIGNED <b>5-2-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Osman Z. Ersoy, M.D.</b>	
22a. SIGNATURE <b>Osman Z. Ersoy, M.D.</b>				22b. DATE SIGNED <b>5-2-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Osman Z. Ersoy, M.D.</b>				22d. ADDRESS <b>Prince Frederick, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF <b>5-6-67</b>		23c NAME OF CEMETERY OR CREMATORY <b>Coopers -Ch. Cem</b>		23d LOCATION (City or Town) (County) (State) <b>Dunkirk Cal Md</b>	
24. FUNERAL DIRECTOR <b>Linkney E. Sewell</b>				25a REC'D BY REGISTRAR <b>MAY 8 1967</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

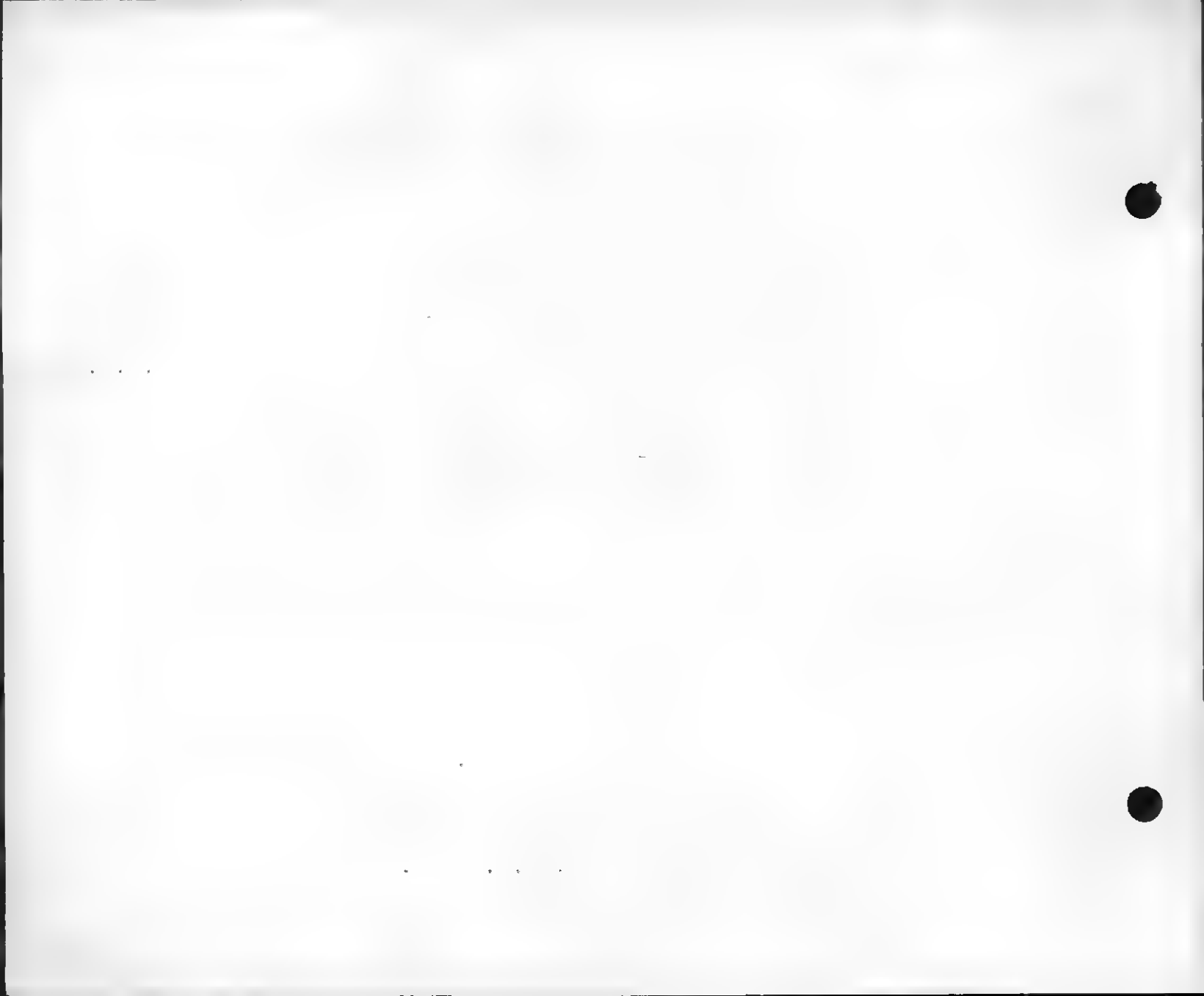
**CERTIFICATE OF DEATH**

26479

6

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>			c. LENGTH OF STAY IN TB <b>615 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Prince Frederick</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Calvert County Hospital</b>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lamar</b> Middle <b>Hollyday</b> Last <b>Steuart</b>				4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-80</b>		9. AGE (In years last birthday) <b>86</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Md. State Parks Com.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Steuart</b>				14. MOTHER'S MAIDEN NAME <b>Mary T. Holliday</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes Spanish-American</b>		16. SOCIAL SECURITY NO <b>220-44-4380</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Steuart Lamar Woodward, Balto. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cornary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Arterio Sclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 8, 1964</b> , to <b>May 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1967</b> , and that death occurred at <b>2:05 a.m.</b> from causes and on the date stated above							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>5/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal, M.D.</b>				22d. ADDRESS <b>St. Leonard, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Middleham Chapel</b>		23d. LOCATION (City or town) (County) (State) <b>Lusby Calvert Md.</b>	
24. FUNERAL DIRECTOR <b>A. Q. Barbaree &amp; Son, Port Republic, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

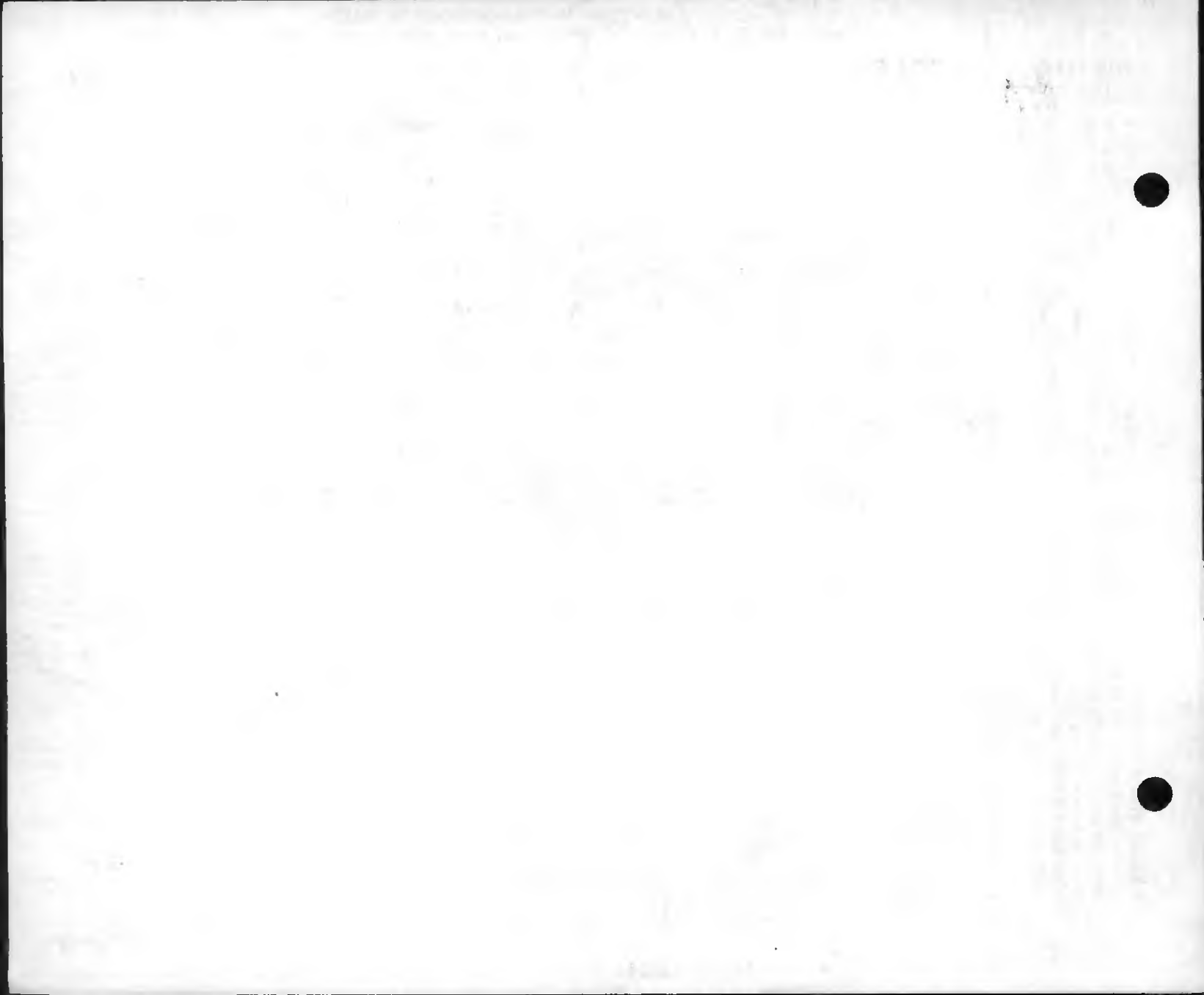
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>850 Berkeley</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vincent Ellsworth Thompson</u> First Middle Last 4. DATE OF DEATH <u>5</u> Month <u>30</u> Day <u>1967</u> Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>6/11/1906</u> 8. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Memrod Thompson</u> 14. MOTHER'S MAIDEN NAME <u>Lucy McKenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>Mr. V. E. Thompson</u> 17. INFORMANT <u>Mr. V. E. Thompson</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>CVRO.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died suddenly in bed</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>Found in bed dead</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>7:40</u> Hour a.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <u>(Home) College H. Road</u> 20f. (City or town) <u>Hyattsville</u> (County) <u>PR</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. 22. DATE SIGNED <u>5/30/67</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>6/2/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u> 23d. LOCATION (City or town) <u>PRINCE GEORGES, MARYLAND</u> (County) (State)			
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> ADDRESS <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u> 25a. REG. NO. <u>JUN 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Prince Frederick</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co H</i>		d. STREET ADDRESS <i>-</i>	
3. NAME OF DECEASED (Type or print) First <i>Emma</i> Middle <i>A</i> Last <i>Wood</i>		4. DATE OF DEATH Month <i>5</i> Day <i>22</i> Year <i>1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-31-1900</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>22</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Pekrul</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-3671484</i>	
17. INFORMANT <i>Wilburn Hoody, Prince Frederick, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line: (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Dead in Hospital before M.D. Saw her</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Knocked at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>1045</i> p.m. <i>5/22/67</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, or transient street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Hugh W. Ward, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <i>5/22/67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 24, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ashbury Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baratow Calvert Md.</i>	
24. FUNERAL DIRECTOR <i>A.A. Hershner &amp; Son, Port Republic, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 21 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

